

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1101

CERTIFICATE OF DEATH

01095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 8 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Rosa		First	Middle	Last	4. DATE OF DEATH Baker	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1876	9. AGE (In years 81 birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Cahall		14. MOTHER'S MAIDEN NAME Susie Cecil						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Pearl Everngaham		Address Queen Anne, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Diseases DUE TO						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Greensboro		(County) (State) Greensboro, Maryland
21. I certify that I attended the deceased from <u>Aug 23</u> , 1957, to <u>Dec 23</u> , 1958, that I last saw the deceased alive on <u>Dec 23</u> , 1958, and that death occurred at <u>10:45A</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>J. F. M. Person</u> PHYSICIAN'S NAME (Type)						ADDRESS (Street, city or town, state) Greensboro		DATE SIGNED Greensboro
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/58		22c. NAME OF CEMETERY OR CREMATORIAL Greensboro		22d. LOCATION (City, town, or county) Greensboro, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boeckris</u>		ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE JAN 2 9 58		24b. REGISTRAR'S SIGNATURE <u>John Smith</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be rejoined to hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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RECEIVE EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Queen Anne MARYLAND		a. STATE MD	b. COUNTY Queen Anne
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill		c. LENGTH OF STAY IN 1b 10 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS Centreville	
3. NAME OF DECEASED (Type or print)		First Mary	Middle M
4. DATE OF DEATH Jan 25 1958		Last Berry	Month Jan
5. SEX Female	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH South Korea
9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Don't Know		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Solomon Brosadway		14. MOTHER'S MAIDEN NAME South Korea	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 159-28-1840	
17. INFORMANT Address Marcha Blake (wife) Burrisville		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE W. Denny Fisher	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/27/58
EXAMINER'S NAME (Type) Edgar L. Lane	22a. BURIAL/CREMATION, REMOVAL (Specify) Jan 28.58		22c. NAME OF CEMETERY OR CREMATORIAL Burrsville
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane	22b. DATE THEREOF Jan 28.58		22d. LOCATION (City, town, or county) Queen Anne Co. MD
24a. REC'D BY REGISTRAR DATE JAN 31 '58		24b. REGISTRAR'S SIGNATURE A. L. Fisher	
VS. A15ME(5) 5M 9/55			

RECEIVED EXAMINER'S CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH-ENVIRONMENTAL

BUREAU V.
RECEIVED
JAN 31 1958

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01097

1. PLACE OF DEATH a. COUNTY		1103 Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		b. STATE MD b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Church Hill RFD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS Church Hill RFD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Lillian R. Middle Gibbs		4. DATE OF DEATH Jan 25		Year 1958	
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 1905		9. AGE (In years last birthday) 53 yrs.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 20-2080		11. BIRTHPLACE (State or foreign country) Prince MD	
13. FATHER'S NAME Don't Know		14. MOTHER'S MAIDEN NAME Don't Know		12. CITIZEN OF WHAT COUNTRY? U. S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-30-2080		17. INFORMANT Sami Gibbs		Address Church Hill RFD	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Organic heart disease				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE W. Henry Fisher		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/27-58	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL OR CREMATION, REMOVAL (Specify) Jan 29-58		22b. DATE THEREOF Jan 29-58		22c. NAME OF CEMETERY OR CREMATORIAL Rosenel		22d. LOCATION (City, town, or county) Queen Anne Co. Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lewis		ADDRESS Church Hill RFD		24a. REG'D BY REGISTRAR JAN 31 '58		24b. REGISTRAR'S SIGNATURE Oldenbach	
VS. A15ME(S) 5M 9/55							

MISSOURI STATE DEPARTMENT OF DEATH
REGULAR EXTRAVAGANCE 2

RECEIVED
1958

2081

BUREAU V. S.

JAN 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01098

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Q.A.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 16 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chestertown R. D.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Kingstown			d. STREET ADDRESS near Kingstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First HERBERT	Middle ELLSWORTH	Last HOFFMAN	4. DATE OF DEATH Jan. 14 1958	Month Jan.	Day 14	Year 1958				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29 1910	9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10b. KIND OF BUSINESS OR INDUSTRY painting		11. BIRTHPLACE (State or foreign country) Cambden, N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Herbert E. Hoffman				14. MOTHER'S MAIDEN NAME Julia Eliz. Quinn							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 571-12-2889		17. INFORMANT Mrs. Lillias Hoffman Chestertown, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)				Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				Coronary artery disease		6 months					
DUE TO (c)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chestertown, Md.		(County)		(State)	
21. I certify that I attended the deceased fram. alive on Jan. 13 1958		May 1957		19. 57, to January 14, 1958		that I last saw the deceased 1: p. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown, Md.		DATE SIGNED 1-15-58	
ACTUAL SIGNATURE A.C. Dick											
PHYSICIAN'S NAME (Type) A.C. Dick											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 18/58		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JAN 20 '58		24b. REGISTRAR'S SIGNATURE Dee Smith					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 20 1958

REFUGEE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01099

1105

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MD b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pondtown		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington R.D. 4	
		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print) Jas. Wm. Lively Jr. 4. DATE OF DEATH Month Day Year Jan 22 1958

5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 27, 1956	9. AGE (in years last birthday) 21 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pondtown, Md.	12. CITIZEN OF WHAT COUNTRY? U. S.
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13. FATHER'S NAME Jas. William Lively	14. MOTHER'S MAIDEN NAME Margaret Davis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT Mother	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 355x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		The fell to floor & was lying - apparently a brain lesion -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and find that death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL SIGNATURE W. Henry Fisher	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1/22/58
EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/25/58	22c. NAME OF CEMETERY OR CREMATORIAL M. PLEASANT Cem. Pondtown	22d. LOCATION (City, town, or county) (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Holloman	ADDRESS The Clifton, Md.	24a. REC'D BY REGISTRAR JAN 27 '58	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR
TO FUNERAL DIRECTOR
VS A15 (4)
15M 9/55

TO HOSPITAL OR
TO FUNERAL DIRECTOR
VS A15 (4)
15M 9/55

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained in the hospital or attending physician.
After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01100

1106

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Q. A.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sudlersville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Sudlersville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sudlersville				d. STREET ADDRESS Sudlersville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First James	Middle Edward	Last Stevens	4. DATE OF DEATH Jan. 17 1958	Month Jan.	Day 17	Year 1958
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23 1880		9. AGE (In years from birth) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant		10b. KIND OF BUSINESS OR INDUSTRY books		11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Bramble Stevens		14. MOTHER'S MAIDEN NAME Juliet Maria Hearn						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-03-3930		17. INFORMANT Lillie Belle Stevens, Sudlersvil Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. b)		Partial occlusion of middle cerebral artery		INTERVAL BETWEEN ONSET AND DEATH		
DUE TO c)		cerebral myocardiitis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fever				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sudlersville		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan. 17</u> , 1958, to <u>Jan. 17</u> , 1958, that I last saw the deceased alive on <u>Jan. 17</u> , 1958, and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE C. H. Metcalfe				ADDRESS (Street, city or town, state) Sudlersville, Md.		DATE SIGNED 1/19/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/20/58		22b. DATE THEREOF 1/20/58		22c. NAME OF CEMETERY OR CREMATORI Sudlersville		22d. LOCATION (City, town, or county) Sudlersville, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. Metcalfe		ADDRESS Sudlersville, Md.		24a. REC'D BY REGISTRAR JAN 22 '58		24b. REGISTRAR'S SIGNATURE W. Metcalfe		

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
JAN 22 1953				
BUREAU Y.				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G225 2-3-58 et

01101

1107

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 63 RT.2		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William Edward Thomas		First	Middle	Last	4. DATE OF DEATH 1 15 1958	Month	Day	Year
S. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/1871 1889	9. AGE (In years last birthday) 68	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer		10b. KIND OF BUSINESS OR INDUSTRY REtired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Iseral Thomas		14. MOTHER'S MAIDEN NAME Martha A. Cephaus						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ✓		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Blanche Thomas		Address Centreville		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X		DUE TO Leber Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 5 days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatoid Arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) ✓						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Centreville		(County) Md. (State) 1-11-58
21. I certify that I attended the deceased from Jan 13 , 1958, to Jan 15 , 1958, that I last saw the deceased alive on Jan 13 , 1958, and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Centreville, Md.								DATE SIGNED
ACTUAL SIGNATURE C.R. Layton		M.D.						
PHYSICIAN'S NAME (Type) C.R. Layton								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/19/58		22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery		22d. LOCATION (City, town, or county) Centreville, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dabill		ADDRESS Eaton, Md.		24a. REC'D BY REGISTRAR DATE JAN 23 '58		24b. REGISTRAR'S SIGNATURE ✓		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar, or to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

CERTIFICATE OF DEATH

DECEASED

NAME

BUREAU V. 6

JAN 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1108

CERTIFICATE OF DEATH

Reg. Dist. No. 01102

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Church Hill</i>		c. LENGTH OF STAY IN 1b <i>Life time</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Church Hill</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>THOMAS</i>	Middle <i>H</i>	Last <i>WHALEY</i>	4. DATE OF DEATH Month <i>JAN</i>	Day <i>27</i>	Year <i>1958</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Nov. 4, 1876</i>	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BARBER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>BARBER</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
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13. FATHER'S NAME <i>Thomas Whaley</i>	14. MOTHER'S MAIDEN NAME <i>Louise Ellsworth</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>211-21-2121</i>	17. INFORMANT <i>Louise Manning</i>	Address <i>Glen Burnie</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>444x</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>My arteriosclerosis</i>		
DUE TO (c) <i>Arteriosclerosis</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	

20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Deale</i>	20f. (City or town) <i>Deale</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
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21. I certify that I attended the deceased from <i>Deale</i> , 1957, to <i>1-27</i> , 1958, stat I last saw the deceased alive on <i>Jan. 22, 1958</i> , and that death occurred at <i>Deale</i> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Deale</i>					
ACTUAL SIGNATURE <i>H. F. M. Peterson</i>	DATE SIGNED <i>1-28-58</i>				

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>JAN 29 1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Church Hill</i>	22d. LOCATION (City, town, or county) <i>Church Hill</i>	(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer L. Lane</i>		ADDRESS <i>Church Hill</i>	24a. REC'D BY REGISTRAR <i>Asbestech</i>	24b. REGISTRAR'S SIGNATURE <i>Asbestech</i>
VS A15 (4) 15M 9/55		DATE JAN 31 '58		

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01103

Reg. Dist. No.

1109

Items 8,9 Film G224 1-15-50 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
Queen Anne MARYLAND		b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville		c. LENGTH OF STAY IN 1b	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Grasonville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Lulu D.		white	white
4. DATE OF DEATH		Month	Day
		JAN	11
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
Female		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> AUGUST 11, 1887
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
70 yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Westmoreland Co Va	
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
S. Dempsey		Emm. Massey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		George White Grasonville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion	
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
W. HENRY FISHER W. HENRY FISHER		1/13-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 14-58	
		22c. NAME OF CEMETERY OR CREMATORIAL Chesterfield	
22d. LOCATION (City, town, or county) Centreville Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Bouton		ADDRESS Baltimore Cremation & Burial	
		24a. REC'D BY REGISTRAR Jan 14 58	
		DATE	
24b. REGISTRAR'S SIGNATURE Asst. Registrar			

BUREAU V. A

JAN 14 1958

RECEIVED